HealthCare Partners, IPA
HealthCare Partners, MSO

# Case Management/Member Advocate Referral

Date: ______________

**PATIENT INFORMATION**

Last Name: ______________________________ First Name: ______________________________

ID#: ______________________ DOB: ______________ Gender: ☐ M ☐ F

Primary phone number: ____________________ Cell phone number: ____________________

E-mail Address: ________________________________

Language(s) spoken/member cognition/cultural preference if any that could influence intervention:

________________________________________________________________________________

Region: ☐Bronx ☐Brooklyn ☐Manhattan ☐Nassau ☐Queens ☐Staten Island ☐Suffolk ☐Westchester

**HEALTH CARE PROXY/GUARDIAN OR POA APPOINTED NAME**

Name:____________________________________________________

Phone number: ________________ E-mail: ____________________ Relationship: ______________

**NAME OF REFERRAL SOURCE/PROVIDER**

Name: ____________________________________________________________________

Phone number: ______________________ Fax number: ______________________

E-mail: ____________________________________________________________________________

**MEDICAL DIAGNOSIS:**

☐ Asthma ☐ Diabetes ☐ Heart Disease/CHF ☐ Overweight/Underweight ☐ HIV/AIDS

☐ Hypertension ☐ Other: ____________________________________________________________

________________________________________________________________________________

**PRIMARY REASON(S) FOR CASE MANAGEMENT/MEMBER ADVOCATE INTERVENTION**

(check all that are being requested)

☐ Support to manage Chronic Disease ☐ Social and Environmental Assessment ☐ Health Illiteracy

☐ Medication Adherence ☐ Mobility (transfer/ambulation) ☐ Caregiver fatigue

☐ Cognitive impairment concerns ☐ Not managing Activities of Daily Living ☐ Falling at home

☐ Risk for Readmission ☐ Other (specify): ______________________________________

________________________________________________________________________________

________________________________________________________________________________

***Home Visit Exclusions:*** *Potential violence, behavioral health as primary driver of referral, patient unable to participate in engagement (i.e. dementia or schizophrenia)*

**Please provide any additional details below:**

**Print and Fax this complete for to HCP at: (516) 941-2145**

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